Facilities Development Division Payment Form

This form is to be used to remit payment for the fee(s) listed below.

Facility Name	OSHPD Facility I.D. Number
Contact Person	Phone Number

Please check appropriate box:

☐ Annual Building Permit: Project # (if applicable) _____

☐ Plan Review Application Project # (if applicable) _____

Scope of Work: _____

☐ Further Fee: Project # _____ Invoice # _____

☐ Radiology Fee: Project # _____ Invoice # _____

☐ Inspector of Record Certification Examination/Application Fee

☐ Anchorage Pre-Appoval Program

☐ Other

Return /Fax To:

Office of Statewide Health Planning and Development
Division of Administration
Accounting Section
1600 Ninth Street, Room 450
Sacramento, California 95814
(916) 653-0730 FAX (916) 654-3200

☐ Check or Money Order

☐ Visa ☐ Master Card ☐ Discover/Novus ☐ American Express

Account number (please print clearly)

$ _____ Exp. Date: _____

Billing Address Phone Number

City State Zip Code

Card Holder's Name Signature